NON-EMERGENT MEDICAL TRANSPORTATION AUTHORIZATION and VERIFICATION

Michigan Department of Community Health
Children's Special Health Care Services Plan Division (CSHCS)

IMPORTANT:

- Non-Emergent Medical Transportation is available to beneficiaries who do NOT have access to a vehicle (public or private), sufficiently equipped for the needs of the beneficiary.
- The beneficiary must have current CSHCS eligibility on the date of service and must be visiting a CSHCS authorized provider for services relating to the beneficiary's CSHCS diagnosis.
- The beneficiary must also meet one or more of the following criteria:
  1. Wheelchair dependent
  2. Bed bound
  3. Medically dependent upon life sustaining equipment that cannot be accommodated by standard transportation.

SECTION 1 – To be completed by the Local Heath Department (LHD): *Type or Print Firmly*

Name of Client / Beneficiary		Client ID Number	DATE(S) OF TRANSPORTATION:
Date of Birth	County of Beneficiary	Client Social Security Number	
Provider / Clinic Name		Provider / Clinic Phone Number ( )	
LHD Agency Name		LHD Authorizing Signature	Date Signed
LHD Agency Phone Number ( )			

SECTION 2 – Parent / Guardian Agreement:

I have read and agree to the following: • The doctor or clinic must provide proof of the visit BEFORE CSHCS will make payment to the Transport Company. • If proof is NOT provided, payment for this transport will be the responsibility of the parent / guardian who requested the transport.	Parent / Guardian Signature	Date Signed

SECTION 3 – To be completed by the Medical Office or Clinic Personnel:

Purpose of Appointment		
Name of Doctor or Clinic	I verify that the client named above was seen at this office on the above date.	
Doctor / Clinic Address	Office / Clinic Personnel Signature	Date Signed
City		

SECTION 4 – To be completed by the Transport Company:

- Please submit an itemized invoice that includes your FE ID Number plus the WHITE copy of this form.
- Your invoice must include loaded miles and specify round trip or one way trip.
- A W-9 & Payee Registration must be on file with the State of Michigan
- Mail these items to:

PAYMENT EXCEPTIONS UNIT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30688
LANSING MI 48909

Name of Transport Company	Transport Company Representative Signature	Date Signed
We agree to accept CSHCS payment as PAYMENT IN FULL for this transport.		

AUTHORITY: Title V of the Social Security Act COMPLETION: Is Voluntary, but is required if CSHCS Program payment is desired.	The Department of Community Health is an equal opportunity employer, services, and programs provider.

MSA-0709 (7-00) (W)

COPY DISTRIBUTION: (WHITE) - Attach with invoice
(YELLOW) - Transport Company
(PINK) - Parent Copy